

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003767	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00132437</p> <p>Unsubstantiated: lack of sufficient evidence</p> <p>Date: 7/11/13</p> <p>Facility Number: 003767</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>Regency Hospital of Northwest Indiana is in compliance with 410 IAC 15-1.6-9, Other services, 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing service, and 410 IAC 15-1.5-2, Infection control, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 08/13/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE